520.034: Interim Changes

The applicant or member must notify the MassHealth agency of any changes occurring before meeting the deductible or during the deductible period. These changes include an increase or decrease in income or an increase in assets.

520.035: Conclusion of the Deductible Process

When the total of submitted bills is equal to or greater than the deductible and all other eligibility requirements continue to be met, the MassHealth agency notifies the applicant that he or she is eligible. The member is eligible for payment of all covered medical expenses incurred during that deductible period, other than those submitted to meet the deductible, as long as the member continues to meet all other eligibility requirements during the balance of the deductible period.

520.036: Copayments Required by the MassHealth Agency

The MassHealth agency requires its members to make the copayments described in 130 CMR 520.038, up to the ~~calendar year~~ maximum described in 130 CMR 520.040, except as excluded in 130 CMR 520.037, and provided that if the payment rate for the service is less than the copayment amount, the member must pay the payment rate for the service minus one cent. ~~If the usual and customary fee for the service or product is less than the copayment amount, the member must pay the amount of the service or product, provided that this amount shall be no greater than the MassHealth payment minus one cent.~~

520.037: Copayment and Cost Sharing Requirement Exclusions

(A) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 520.038:

(a) members younger than 21 years old;

(b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15th, she is exempt from the copayment requirement until August 1st);

(c) MassHealth Limited members;

(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for individuals with intellectual disabilities or who are admitted to a hospital from such a facility or hospital;
(f) members receiving hospice services;
(g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*, if they do not receive MassHealth Standard, or MassHealth Family Assistance;
(h) members who are former foster care individuals and who are eligible for MassHealth Standard until they reach the age of 21 or the age of 26, as specified in 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-Care Individuals*;
(i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization or an urban Indian organization, or through referral, in accordance with federal law.
(j) "referred eligible" members, who are:
1. persons who receive Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA) and who receive MassHealth Standard under 130 CMR 505.002(A)(2) or 130 CMR 519.002(B);
2. persons who receive Transitional Aid to Families with Dependent Children (TAFDC) cash assistance from the Department of Transitional Assistance (DTA) and who receive MassHealth Standard under 130 CMR 505.002(A)(3);
3. children, young adults, and parents and caretaker relatives who receive Emergency Aid to the Elderly, Disabled and Children (EAEDC) cash assistance and who receive MassHealth Standard under 130 CMR 505.002(K) or 130 CMR 519.002(D), MassHealth Family Assistance under 130 CMR 505.005(G) or 130 CMR 519.013(C), or MassHealth CarePlus under 130 CMR 505.008(B);
4. children receiving medical assistance under 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, because they are receiving Title IV-E or state-subsidized adoption or foster-care assistance
5. persons who receive extended eligibility for MassHealth Standard under 130 CMR 505.002(L) or 130 CMR 519.002(C); and
6. persons who receive MassHealth Standard or CarePlus because they are eligible for Refugee Medical Assistance (RMA) under 130 CMR 522.002: *Refugee Resettlement Program*; and

(k) members whose applicable income for the purposes of calculating copayments is at or below 50% of the FPL when adjusted for family size.

~~(2) Members who have accumulated copayment charges totaling the monthly maximum of for $250 per calendar yearpharmacy services do not have to pay further MassHealth copayments on for pharmacy services during the calendar yearmonth in which the member reached the MassHealth copayment maximum for pharmacy services.~~

(~~3~~2) Members who are inpatients in a hospital do not have to pay a copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 520.038:

(1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(2) detoxification and maintenance treatment of an individual for substance use disorders using FDA approved medications (including methadone, buprenorphine, buprenorphine/naloxone, and naltrexone);
(3) preventive services assigned a grade of 'A' or 'B' by the United States Preventive Services Task Force (USPSTF), or such broader exclusion as specified by MassHealth;
(4) all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP);
(5) smoking cessation products and drugs;
(6) emergency services; and
(7) provider-preventable services as defined in 42 CFR 447.26(b).

520.038: Services Subject to Copayments

MassHealth members are responsible for making the following copayments for pharmacy services unless excluded in 130 CMR 520.037.

(A) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and

(B) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.

520.039: Members Unable to Pay Copayment

Providers may not refuse services to a member who is unable to pay at the time the service is provided. However, the member remains liable to the provider for the copayment amount.

520.040: Maximum Cost Sharing

(A) Members are responsible for the MassHealth copayments described in 130 CMR 520.038~~,~~ up to ~~the~~ a monthly maximum ~~of $250 for pharmacy services per calendar year.~~ of 2% of applicable monthly income. Each member's monthly copayment cap will be calculated using 2% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, and assigning the member a monthly cap of the nearest $10 increment that corresponds to 2% of the applicable income without exceeding 2%. A more detailed explanation of this calculation is publicly available on MassHealth's website.

(B) Members are responsible for MassHealth premiums described in 130 CMR 506.012 up to a monthly maximum of 3% of applicable monthly income, except no such limit applies to CommonHealth members. Each member's monthly premium cap will be calculated using 3% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable. A more detailed explanation of this calculation is publicly available on MassHealth's website.

REGULATORY AUTHORITY

130 CMR 520.000: M.G.L. c. 118E, §§ 7 and 12.